DSS-CP-506 10/05 **PLEASE RETURN TO:**

HEALTH REPORT

Part A: Physical exam – This section is to be completed by a physician, physician's assistant or certified nurse practitioner.

Note to Medical Professional:

_____ is applying to be a_____
(Name of Applicant)

Your opinion as to this person's freedom from physical or mental illness which might be detrimental to the care of children is a governing factor in his/her approval. Be assured that this information will be used for licensing/approval purposes only. A physical exam given to the applicant within one year prior to this application is acceptable for purposes of meeting this requirement.

Date when the applicant was seen: _____ Is the applicant under treatment for chronic illness?

_____ Yes_____ No If yes, what is the diagnosis? _____

What medications are prescribed? _____

General condition of health: _____

Are there any emotional, mental or physical factors that would interfere with this individual's ability to care for children in their home? Please explain. _____

_____

_____

Print Medical Professionals Name:_____

Signed: _____ Date: _____
Signature of MD, PA or CNP

Please see the back of this form for T.B. test/exam and immunizations report.

Part B: T.B. Tests - This section is to be completed by a nurse, certified nurse practitioner, physician's assistant or physician

Note to medical personnel:
Licensing standards require that an applicant and each household member who is 18 years of age or older must have a mantoux tuberculin test. Individuals who react to T.B. tests and have completed a course of INH therapy are exempt from testing. Individuals who react to T.B. tests but have not completed a course of INH therapy are to be referred to a physician for verification of freedom from disease. Please record the T.B. test results below.

NAME	DATE OF TEST	RESULT OF TEST	DATE COMPLETED COURSE IN INH	REACTS TO TESTING NO INH. – REFERRED TO M.D.

Signed: _____ Date: _____
Signature of Nurse, CNP, PA or MD

This section is only to be completed if the applicant is a reactor to T.B. tests and has not completed a course of INH therapy.

Please verify this individual's freedom from infection if (s)he is a reactor to T.B. tests.

_____

_____

Signed: _____ Date:_____
Signature of MD, PA or CNP

Part C: Immunization Record – This section may be completed by the applicant and is to document the immunizations of his/her own children who are under the age of 18. Please indicate the dates of the immunizations in the appropriate box. S.D. Law allows for medical and religious exemptions to immunization if the immunization would endanger the health of the child or if a parent's religion prohibits immunization. Please inform the licensing worker if you wish to claim an exemption.

NAME OF CHILD	POLIO	Hib	MMR	Hep B	DTP
Name:					
DOB:					
Name:					
DOB:					
Name:					
DOB:					
Name:					
DOB:					
Name:					
DOB:					

I certify that this is the correct record of my children's immunizations.

Signed: _____ Date: _____
Signature of Applicant